STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated survey conducted at Mt. Baker Care Center on 09/11/13, 09/12/13, 09/16/13, 09/17/13, 09/19/13, 09/26/13, and 09/30/13. A sample of 6 residents was selected from a census of 50. The sample included 1 current resident and the records of 5 former and/or discharged residents. The following were complaints investigated as part of the survey: 2836145 2853069 2851501 The survey was conducted by: [redacted] MS, RN The survey team is from: Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, Region 2, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 Fax: (360) 651-6940 Mike Amberse 10/04/13 Residential Care Services Date	F 000	Preparation, and or execution of this Plan of Correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and or executed solely because it is required by the provisions of federal and state laws RECEIVED OCT 14 2013 ADSA/RCS Smokey Point	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sandra L. Kimble	Administrator	10-14-2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify requested mortuary services and accurately document mortuary preferences for two of three residents (1 and 3) records were reviewed. Failure to provide preferred mortuary services resulted in Resident 1's body sent to the wrong mortuary and delayed her funeral service. Failure to identify the preferred mortuary for other residents in their clinical records placed residents at risk of similar results. Findings include: 1. On 10/03/13 at 3:45 p.m., the Director of Nursing Services reported she understood the software application used in the building required staff to enter a funeral home preference in order to complete the admission for any resident's electronic clinical record. On 09/17/13 at 11:16 a.m., Staff D reported she entered a single funeral home as default for all residents when initiating the electronic clinical record for all residents. She updated the entry whenever nursing either sent her a written message or phoned her and gave her a different name. If no staff provided an update or confirmation of the preferred funeral home - the	F 250	**483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE** **Correction of the deficiency, as it relates to the resident.** This Hospice resident has since expired. **Protection of residents in similar situations.** The former practice, to write a default mortuary, on the medical record, has been discontinued. The identification of the mortuary will remain blank, until such time as the Resident/family have indicated their preference to the Social Worker or the nurse. That information will then be relayed to the Medical Records clerk who will enter the information on the face sheet of the resident's medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 2 original default listing remained as the selection for all residents. On 09/04/13 at 3:08 p.m., the family member of Resident 1 reported the resident and another family member selected, prearranged and prepaid for mortuary care and funeral services with a specific funeral home. Although this family member had not known the name of the selected funeral home at the time of Resident 1's death, she learned it was not the one the facility defaults into the clinical records of all residents. The family member was present when Resident 1 died on the evening of [redacted]/13. She remained in the building until the mortician arrived about 1 a.m. No staff asked her what was the fueral home preference of the family and deceased resident. The mortician was from the wrong mortuary. The family member stated Resident 1's body was kept in the wrong fuenral home for 2 days while the family contacted the correct one preselected by the resident. On 09/19/13 at 8:30 a.m., the family member who assisted Resident 1 with prearrangements at the selected funeral home reported the hospice nurse asked about mortuary preference when Resident 1 initiated hospice services. She saw that nurse write down the name for hospice records. This family member stated no staff from the facility inquired what funeral home Resident 1 and the family preferred. Review of the clinical record of Resident 1 revealed on 07/08/13 nursing noted family were present when Resident 1 expired. Nursing notified hospice services and the defaulted funeral home. There was no evidence of documentation of any inquiry to the family of	F 250	**Measures taken or systems altered, to ensure that the problem does not recur.** The system to enter the mortuary information on the medical record, has been altered as above, to ensure that the problem does not recur. Current resident's medical records face sheets will be audited for accuracy of the preferred mortuary **Plan to monitor performance, to ensure that solutions are sustained.** Monthly audits will be conducted by Medical Records and reported to the Quality Assurance Committee **Date when corrective action will be completed.** 11-1-2013 **Title of the person responsible to ensure correction.** Social Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 3 funeral home preference. 2. Resident 3 was admitted in [redacted] 2013 with diagnoses including chronic [redacted] and weakness. On 07/25/13 she was initiated on hospice services. She expired on [redacted] /13. Review of the clinical records of Resident 3 revealed the default funeral home was identified as funeral home preference for the resident. Nursing notes, dated 08/31/13, documented a family member requested the facility notify a different funeral home. Nursing documented the preferred funeral home was notified.	F 250		
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, a facility staff member failed to meet professional standards for nursing care services. Failure to identify, assess, notify, plan and implement individualized care management interventions for Resident 1 resulted in harm of unaddressed increase in pain without adequate relief. Findings include: Resident 1 was admitted in [redacted] 2013 after recent colostomy intervention for [redacted] and bowel obstruction. She changed to hospice services on 07/05/13. All current medications and laboratory orders were discontinued on that date. Her new orders, started on 07/05/13,	F 281	**483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** **Correction of the deficiency, as it relates to the resident.** This hospice resident has since expired. **Protection of residents in similar situations.** DSHS was notified of the incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 4 included pain relief and nausea/vomiting medications only. The goal of these medications was effective management and control of pain and nausea/vomiting. Because Resident 1 was identified as high risk of death in the next few days, hospice services focused on comfort for Resident 1. Hospice records noted Resident 1 stated she was satisfied with her level of comfort on 07/05/13. On 09/04/13 at 3:08 p.m., a family member reported she stayed in Resident 1's room during the night of 07/07/13. She stayed in the room because she thought if she exited, Resident 1 would not receive care. Resident 1 was unable to swallow and keep anything down. The family member stated she spent most of the time wiping fluids from the mouth and chin where she held a small basin to catch the fluids that leaked from her mouth and filled the basin every 4-5 minutes almost all night long. The family member told Staff A, who was assigned to care for Resident 1 that night. Staff A failed to assess Resident 1. Staff A failed to notify hospice services or the physician of Resident 1 of the changes in her condition. A family member telephoned hospice services about 5 a.m. On 09/16/13 at 1:30 p.m., Staff B reported all nursing staff were oriented when hired to notify physicians and/or hospice services whenever a resident had an acute change in condition. Staff B explained hospice services can often obtain medications faster than notifying a physician and then ordering medications from the pharmacy. Staff B stated all residents who have hospice services have a sticker attached to their clinical record as an alert for staff. The kardex at the nursing station also has the contact details for	F 281	The nurse was suspended pending completion of the investigation of this incident.. Evidence was found to support the allegation of neglect against the nurse. The nurse was terminated. **Measures taken or systems altered, to ensure that the problem does not recur.** Hospice provided a one hour in-service for all staff, regarding Hospice services/standards with emphasis to call Hospice 24/7 when pain is not controlled for any Hospice patient. The attending physician may also be called. Information about Hospice and 24/7 availability, is provided to all new employees. A 30 minute in-service was provided on all shifts, regarding effective pain control, including assessment, documentation of response to the intervention and reassessment with any secondary interventions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 hospice services. On 09/12/13 at 1:15 p.m., the Director of Nursing Services (DNS) and the Administrator reported staff are trained to notify hospice services or physicians whenever a resident has a change in condition. Staff A failed to follow this policy. Staff A failed to assess for pain and pain relief with the current intervention(s) during that night of 07/07/13. Such an assessment and evaluation are part of pain management for residents. The DNS stated Staff A should have contacted hospice services for a change in the route of administration of the pain relief medications for Resident 1. Review of the hospice clinical record revealed no evidence of documentation that any staff from the building telephoned hospice services during the night of 07/07/13. Review of the facility clinical record revealed similar findings. Staff A noted Resident 1 had "multiple complaints and requests" during the night, including pain, difficulty sleeping, anxiety, sore throat and frequent regurgitation of thin brown fluid." Staff A documented the family contacted hospice services, who telephoned Staff A at 5:30 a.m. and stated a hospice nurse would come in to assess Resident 1. Review of the facility investigation revealed they concluded Staff A should have notified hospice services or the physician of Resident1 for proactive orders. This procedure is part of the plan of care for a hospice resident in the building. Additionally, the investigation noted this expectation was appropriate for any licensed nurse practicing in the building.	F 281	**Plan to monitor performance, to ensure that solutions are sustained.** Patients experiencing pain, are monitored each shift by the medication nurses. Oversight by the DNS and RCMs is provided by monitoring of the MARS and the 24 hour clinical report, to determine the effectiveness of pain interventions, including medications. Clinical rounds evaluate the effectiveness of pain management for individual patients. The results of these monitoring efforts will be reported to the Quality Assurance Committee. **Date when corrective action will be completed.** 11-1-2013 **Title of the person responsible to ensure correction.** Director of Nursing Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6	F 309		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to manage pain for Resident 1. Failure to assess, notify, and implement interventions for Resident 1 resulted in harm of inadequate pain relief. Findings include: Resident 1 was admitted in [redacted] 2013 with multiple diagnoses including recent [redacted] for metastatic [redacted] cancer. Her Minimum Data Set assessment, dated 05/28/13, identified her memory and recall abilities as 13/15 possible points on the memory assessment tool. The facility used a verbal report pain scale of 0-10, with 10 being the highest level for pain. Her nursing admission assessment, dated 05/21/13, identified Resident 1 reported she "always had pain in my belly, 8/10." Her physician initially ordered Tylenol for pain and changed that to tramadol, a pain relief medication, a few days after admission. On 09/26/13 at 08:46 a.m., a hospice nurse reported he conducted the initial assessment and	F 309	**483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING.** **Correction of the deficiency, as it relates to the resident.** This hospice resident has since expired. **Protection of residents in similar situations.** DSHS was notified of the incident. The nurse was suspended pending completion of the investigation of this incident. This facility completed the investigation of this incident and found evidence to support the allegation of neglect. The nurse was terminated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 opened hospice services for Resident 1 on 07/05/13. He reviewed those services with the family. These services focused on pain management with a goal to keep a person comfortable. Review of the hospice record, dated 07/05/13, revealed documentation Resident 1 experienced increased nausea, pain and weakness. She experienced pain daily. It was chronic in duration and frequently interrupted her sleep. It was controlled with medication intervention. She stated no pain was acceptable for her. Resident 1 also had moderate nausea and/or vomiting. The record noted Resident 1 had bowel obstruction and she was at risk of death in the coming days. All previous medication and laboratory orders were stopped. New orders for pain relief medications included: · [redacted] by mouth every hour as needed for mild to severe pain - titrate to effective dose. · [redacted], a narcotic pain relief medication, by mouth every 4 hours as needed for pain relief. · [redacted] a narcotic pain relief medication, by mouth every 4 hours as needed for pain relief. On 09/04/13 at 3:08 p.m., a family member reported she visited Resident 1 on 07/07/13. She stated Resident 1 did not drink as she had great difficulty swallowing - fluids dribbled from her mouth. Between 10 and 11 p.m. that night, the family member reported she held a small kidney-shaped basin under Resident 1's chin. The basin filled between ½ and ¾ full approximately every 5 minutes throughout the remainder of the night. Resident 1 could not hold the morphine under her tongue. Brown matter leaked from her mouth. The family member told	F 309	**Measures taken or systems altered, to ensure that the problem does not recur.** Staff have been educated by Hospice and through the facility in-service on Pain Management. Pain is not to be neglected. Information about Hospice and 24/7 availability is provided to all new employees. **Plan to monitor performance, to ensure that solutions are sustained.** Clinical rounds and review of MARs and 24 hour clinical reports will validate that resident's pain is being managed. Results will be reported to the Quality Assurance Committee. **Date when corrective action will be completed.** 11-1-2013 **Title of the person responsible to ensure correction.** Director of Nursing Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 Staff A what was occurring. The family member did not recall Staff A either touching or assessing Resident 1 for pain/comfort. Rather, Staff A suggested a sedative for Resident 1. The family member asked whether a sedative might result in aspiration for Resident 1. Staff A did not reply to the question. The family member stated Staff A did not notify hospice services during the night of the changes for Resident 1. Staff A entered Resident 1's room every 1-2 hours throughout the night and told the family member Resident 1 "was sick." The family member did not leave Resident 1's room during the night because she thought Resident 1 "would be covered in brown matter." On 09/11/13 at 5:34 p.m., Staff C reported he cared for Resident 1 the night of 07/06/13 and 07/07/13. He stated she had a problem keeping food down both dates. He notified Staff A of the situation. On 07/07/13, any medication Staff A administered, Resident 1 vomited. Staff C brought "stacks of towels and washcloths" throughout the night for the family to use on Resident 1. Staff C observed Resident 1 had pain and distress throughout the night. Staff C recalled the family asked where was Staff A throughout the night. He reported the family concerns to Staff A. On 09/16/13 at 1:30 p.m., Staff B reported she received report from Staff A the morning of 07/08/13. Based on that report, Staff B thought Staff A should have telephoned hospice services during the night. Staff B showed Staff A the "neon yellow" sticker on Resident 1's chart. The sticker listed the telephone number of hospice services and indicated they were available 24 hours/day.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505376	A. BUILDING _____ B. WING _____	C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT BAKER CARE CENTER	2905 CONNELLY AVENUE BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9 Staff B stated she observed fluids dribbling from Resident 1's mouth that morning. She described the fluids as "alternating poop brown to dark chocolate color." Sometimes the fluids were thin; sometimes particles were present. Resident 1 was retching about every 20-30 minutes. Whenever Resident 1 attempted to swallow water, it came back up immediately. Resident 1's tongue was reddened and cracked. When Staff B went to telephone hospice services, she saw the hospice nurse entering the building. She explained Resident 1's condition and requested pain relief and nausea medications for the resident. On 09/04/13 at 3:08 p.m., a family member stated she returned to visit Resident 1 about 8 p.m. on 07/08/13. Another family member told her at that time, Resident 1 had not vomited in the past 2 hours. Resident 1 was quiet and smiled at the family member. The family member thought the [redacted] was finally working for Resident 1. Review of the hospice record revealed documentation, dated 07/08/13 at 1:10 p.m, Resident 1 continued to have nausea and vomiting throughout the hospice nurse visit. The hospice nurse noted that Resident 1 showed no non verbal signs of pain following administration of 3 milligrams of [redacted] subcutaneously (an injection under the skin). The hospice nurse discontinued all medications by mouth for Resident 1. See F281 - lack of professional standards for additional details.	F 309		

Washington State Department of Social & Health Services

Aging and Adult Services Administration

NURSING HOME SURVEY REPORT

STATE REQUIREMENTS

1.	
Page 1 Pages	
2. DATES OF DATA COLLECTION	11/4/13

3. NAME OF FACILITY	4. TYPE OF SURVEY	5. TIME OF SURVEY
Mt Baker Care Center	☐ Full ☒ Post ☐ Complaint ☐ Other (*Specify*)	☒ Day ☐ Night ☐ Weekend ☐ Holiday

6. ADDRESS	STREET	CITY	STATE	ZIP	7. LICENSE NUMBER
2905	Connelly Avenue	Bellingham	WA.	98225	1333

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.

☐ The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on HCFA form 2567, date: 09/30/2013

•• Licensee must complete column 14

☒ The following deficiencies were determined to be corrected.

9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	•• 14. LICENSEE'S PLANNED DATE OF CORRECTION
-0960(1)	15 (g)	F250		☐	
-1620(2)(b)(i)(ii)	20 (k)(3)(i)	F281		☐	
-1060(1)	25	F309		☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	

13. SURVEYOR'S SIGNATURE(S)

SIGNATURE	DATE	SIGNATURE	DATE
Roberta Crawford	11/4/13		
SIGNATURE	DATE	SIGNATURE	DATE

14. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE